



State of Tennessee  
Health Facilities Commission  
Andrew Jackson State Building  
502 Deaderick Street, 9<sup>th</sup> Floor, Nashville, TN 37243  
[www.tn.gov/hfc](http://www.tn.gov/hfc) Phone: 615-741-7221

April 13, 2026

Sent Via Email

Ruby D. Wilson ([rubywilson@heart2heartholisticchcs.com](mailto:rubywilson@heart2heartholisticchcs.com))  
Heart to Heart Holistic Healthcare Services  
3200 W End Ave  
Ste 500  
Nashville, TN 37203

Facility Type: Home Health Agencies  
License Number: 717

Dear Ruby Wilson:

It is my pleasure to inform you that your application for licensure of Heart to Heart Holistic Healthcare Services located at 1321 Weeping Cherry Ln, Hermitage, TN 37076 has been initially approved effective April 13, 2026. The license number shall be 717. For this initial approval to become final and permanent, your application must be ratified by the Commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for May 27, 2026. **You are hereby authorized to commence operation pending the final decision of the Commission.**

**For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The West Tennessee Regional Office phone number is 731-984-9721.**

If the Commission **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Commission's final decision.

If the Commission **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

Please contact me if I can be of further assistance.

Sincerely,  
**Eddie J. Stewart**  
Eddie J. Stewart  
Health Facilities Program Manager  
Health Facilities Commission  
Licensure and Regulation Division

cc: West Tennessee Regional Office



**APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY**

Facility Type: HOME HEALTH AGENCY License # (if applicable): HL303 County: DAVIDSON  
Initial  Renovation \_\_\_\_\_ Satellite/Off Campus Location \_\_\_\_\_  
Physical Plant/Services/New Addition \_\_\_\_\_ Relocation/Replacement Facility \_\_\_\_\_  
(Circle One) (Circle One)

Facility Name: HEART TO HEART HOLISTIC HEALTHCARE SERVICES

Address: 1321 WEEPING CHERRY LANE City: HERMITAGE Zip Code: 37076

Application and fee on file in Central Office (CO)?: Yes  No \_\_\_\_\_ CON #: \_\_\_\_\_

Project #: \_\_\_\_\_ Phase: \_\_\_\_\_ of \_\_\_\_\_

Facility approved for (if satellite/off campus site include address): Approved for the following counties: ALL COUNTIES

Sprinklered: \_\_\_\_\_ (Full 100%) Partial: \_\_\_\_\_ (%)

Licensed bed count from: \_\_\_\_\_ to \_\_\_\_\_ Number of beds increased/decreased: \_\_\_\_\_

If secured unit, number of beds in unit: \_\_\_\_\_ If Alzheimer's unit, number of beds in unit: \_\_\_\_\_  
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor: CELIA SKELLEY, QUINTEN HODGE Date: 4/10/2026

Fire Safety: \_\_\_\_\_ Date: \_\_\_\_\_

CD Approved: Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ Health Survey Required: Yes  No \_\_\_\_\_; if Yes, please indicate which region: West TN

Facility's Letter of Notification received in Licensure: Yes  No \_\_\_\_\_  
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc) approved and received in regional office: Yes \_\_\_\_\_ No \_\_\_\_\_ N/A  
(NOTE: With exception of Initial Licensure Approvals)

Effective date: 4/13/2026 Licensure is recommended: Yes  No \_\_\_\_\_  
(Completed by Central Office Licensure Staff)

Donald Nelson, ACC Supervisor 4/13/2026  
Regional Administrator/Facilities Construction Director or Designee Date

Eddie Stewart 4/13/2026  
Licensure Program Unit Staff Date

## Application Summary

1/9/26 10:19 AM

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### Application Detail

License Type: **Home Health Services: Licensed**  
Application: **Home Health Services: Initial Application**  
Application Date: **01/09/2026 (mm/dd/yyyy)**

### Organization Detail

Organization Name: **Heart to Heart Holistic Healthcare Services**  
Organization Type: **Limited Liability Company**

### Addresses

#### Mailing Address

Address: **1321 Weeping Cherry Ln**  
**DAVIDSON**  
**Hermitage, TN**  
**37076**  
**US**

Phone Number: **615-568-7348**

Extension:

E-mail Address: **[ruby.wilson@heart2heartholisticchcs.com](mailto:ruby.wilson@heart2heartholisticchcs.com)**

#### Administrative

Name: **Ruby D. Wilson**

Address: **3200 W End Ave**  
**Ste 500**  
**DAVIDSON**  
**Nashville, TN**  
**37203**  
**US**

Phone Number: **615-568-7348**

Extension:

E-mail Address:

**ruby.wilson@heart2heartholisticchcs.com****Emergency Contact**

Name:

**Ruby D. Wilson**

Address:

**1321 Weeping Cherry Ln****DAVIDSON****Hermitage, TN****37076****US**

Phone Number:

**615-568-7348**

Extension:

E-mail Address:

**ruby.wilson@heart2heartholisticchcs.com****Ownership of Building**

Name:

**Heart to Heart Holistic Healthcare Services**

Address:

**1321 Weeping Cherry Ln****DAVIDSON****Hermitage, TN****37076****US**

Phone Number:

**615-568-7348**

Extension:

E-mail Address:

**ruby.wilson@heart2heartholisticchcs.com****Legal Entity**

Name:

**Heart to Heart Holistic Healthcare Services**

Address:

**3200 W End Ave****Ste 500****DAVIDSON****Nashville, TN****37203**

**US**

Phone Number:

**615-568-7348**

Extension:

E-mail Address:

**ruby.wilson@heart2heartholisticchcs.com****License Attributes Selected**

Specialty

**Home Health Agency****Home Health Aid Services****Homemakers Services****Skilled Nursing**

Counties

Counties - Davidson, Williamson, Wilson, Rutherford, and Sumner

Qualification/Certification

ejs

~~All Counties~~

PEDIATRICS

EEOICPA

**Basic License Data**

Do you have Branch Offices? If yes, enter number(s) of branch(es).

**0**

Provide Administrator's Name:

**Ruby D Wilson**

Provide the Ownership's Name:

~~Ruby D Wilson~~ ejs

Heart to Heart Holistic Healthcare Services

Is your facility accredited by a federally approved accrediting body?

**No**

What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?

**Free Standing**

Provide a Yes or No, if your facility is Chain Affiliated

**No**

Provide a Yes or No, if your facility has a Holding Company

**No**

Provide a Yes or No, if your facility has a Parent Company

**No**

Do you have Other Licensed Facilities in the state of Tennessee and/or other states?

**No**

Do you have a contract with a management firm to operate this facility?

**No**

Have any owners ever been denied a license, had a license suspended or revoke,

**No**

had a suspension of admissions or paid any civil monetary penalties for a health care facility in Tennessee or in any other state?

Provide a Yes or No, Do you provide services to a pediatric population? **Yes**

Provide a Yes or No, Is your agency a provider in the EEOICPA federal program? **Yes**

### Administrator's Conviction Information

Administrator convicted of crime?: **No**

### Individual Owners, Partners, Director or Head of Government Entity

The name of the individual owner, partner, director of the corporation or head of the government: **Ruby D Wilson**

Street: **1321 Weeping Cherry Ln**

City: **Hermitage**

State: **Tennessee**

Zip: **37076**

### Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?: **No**

Have any of owners of the disclosing entity had a suspension of admissions?: **No**

Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state?: **No**

### File Attachments

PUBLIC NOTICE LOI.docx

53669.jpg

### Fees

Initial License Fee **\$1404.00**

Total Amount Due: **\$1404.00**

### Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Home Health Services facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Home Health Services facility. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.



State of Tennessee  
Health Facilities Commission

502 Deaderick Street, Andrew Jackson Building, 9<sup>th</sup> Floor, Nashville, TN 37243  
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

**INITIAL NOTIFICATION OF HOME HEALTH ACCREDITATION FOR  
CON EXEMPTION**

**Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a health care institution or initiates any service specified in T.C.A. 68-11-1607 (a) (3) pursuant to the exemption provided in T.C.A. 68-11-1607 (r) or T.C.A. 68-11-1607 (r). This form must be emailed to hsda.staff@tn.gov.**

1. **REPORTING DATE:** 2/13/26

2. **NAME AND ADDRESS OF PROVIDER**

Heart to Heart Holistic Healthcare Services

**Name**

3200 W End Ave Suite 500

**Address**

Nashville

TN

37203

**City**

**State**

**Zip**

3. **CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION**

Ruby D. Wilson

Owner/Administrator

**Name**

**Title**

ruby.wilson@heart2heartholistichcs.com

**Email Address**

Heart to Heart Holistic Healthcare Services

**Company Name**

1321 Weeping Cherry Ln

**Address**

Hermitage

TN

37076

**City**

**State**

**Zip**

615-568-7348

615-551-4192

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**Phone Number**

**Fax Number**

**4. IF SEEKING THE ESTABLISHMENT OF A HOME HEALTH AGENCY UNDER EXEMPTION, DATE OF LICENSE SUBMISSION:**

1/9/26

**5. IF CURRENTLY LICENSED, PROVIDE LICENSE #:**

**LIST CURRENT LICENSED COUNTIES:**

**COUNTIES LICENSED UNDER EEOICPA:**

**COUNTIES LICENSED UNDER PEDIATRIC**

**COUNTIES LICENSED AS HOME INFUSION ONLY:**

**LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:**

**6. DESCRIPTION OF EXEMPTED ACTIVITY:**

**LIST OF EXEMPTED COUNTIES TO BE ADDED UNDER THE FOLLOWING TYPES:**

**PEDIATRIC:** Davidson, Williamson, Wilson, Rutherford, Sumner

**EEOICPA:** Davidson, Williamson, Wilson, Rutherford, Sumner

**7. NAME AND ADDRESS OF PROVIDER**

Heart to Heart Holistic Healthcare Services

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**Name**

3200 W End Ave Suite 500

---

**Address**

Nashville

TN

37203

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**City**

**State**

**Zip**

**8. ACCREDITATION (must be completed within 2 years of initial licensure)**

**Please Check**

*(Be advised that some accreditation organizations require 10 or more patients at a minimum before starting accreditation proceedings.)*

- Community Health Accreditation Program, Inc.
- Accreditation Commission for Health Care and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives
- Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects;

**I UNDERSTAND THAT A HOME HEALTH AGENCY THAT PROVIDES HOME HEALTH SERVICES WITHOUT A CERTIFICATE OF NEED TO PEDIATRIC AND/OR EEOICPA PATIENTS THAT FAILS TO COMPLY WITH THE ACCREDITATION REQUIREMENTS IS SUBJECT TO LICENSURE SANCTIONS.**



2/13/26

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**Signature**

**Date**

Ruby D. Wilson

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**Printed Name**